

| HEALTH RECORD   | CHRONOLOGICAL RECORD OF MEDICAL CARE  |
|---|---|
| SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION <i>(Sign each entry)</i>  |   |
| <b>Mental Health Clinic</b><br><b>Nellis AFB, NV</b><br><b>NEW PATIENT EVALUATION</b>   |   |
| (Page 1 of 10)  |   |
| <p>(Please circle the correct response)</p> <p>I am presenting to this session <u><b>voluntarily</b></u>: <b>YES</b> / <b>NO</b> (If no, please inform your provider)</p> |   |
| <i>Provider Note:</i>   |   |
| <b>S: I. Demographics:</b> Please complete ALL information on this page including "Patient's Identification" section at bottom right of page.                             |   |
| <b>Name (Last, First MI):</b>   | <b>Date/Time:</b>   |
| <b>Age:</b>   | <b>Special Duty Status (circle one)</b><br>TS/SCI   PRP   FLYING   WEAPONS   Not Applicable |
| <b>Local Mailing Address:</b>   | <b>Home Phone:</b><br><b>Work Phone:</b><br><b>Pager or Cell phone:</b>                     |
| <b>Command Information:</b><br><b>Unit:</b><br><b>1<sup>st</sup> Sgt's Name:</b>  |   |
| <b>Ethnic Group (please write in):</b>  | <b>Spouse's Name:</b>   |
| <b>Marital Status (please circle one)</b><br>Single   Engaged   Married   Divorced<br>Living with a partner   Widowed   Separated   | <b>Time in current relationship</b><br><b>Number of previous spouses</b>                    |
| <b>Please list your children's names, ages, genders, and locations:</b>   |   |
| <b>Military Member's Time in Service:</b>   | <b>Time at Base:</b>  |
| <b>Primary Care Facility:</b>   | <b>Primary Care Manager's Name (if known):</b>  |
| CONTINUE ON NEXT PAGE after completing Patient Identification Section<br>(SEE BELOW RIGHT PORTION OF FORM)  |   |

**DO NOT WRITE IN THIS SECTION****FOR STAFF USE ONLY!**

|   | Y | N | N/A |
|---|---|---|-----|
| Have you gone over Patient Information Sheet (limits of confidentiality, rights/responsibilities, record keeping, provider options, and feedback about services)?   |   |   |     |
| Is pt on PRP? Flyer?  |   |   |     |
| Does pt have security clearance higher than secret?   |   |   |     |
| Does pt carry a weapon on his/her job on a regular basis?   |   |   |     |
| Is pt currently on a medical profile for a mental health condition?   |   |   |     |
| Does pt history indicate a concern about harm to others or self?  |   |   |     |
| Is Privacy Act Statement signed (DD Form 2005)?   |   |   |     |
| Ask verbatim: Are you here voluntarily or at the direction of your commander or supervisor?   |   |   |     |
| (IAW AFI 44-109, 4.3.2, if member says the latter and the commander has not initiated a CDE, provider must contact commander to determine if a CDE is intended. If not, the provider shall inform pt that the evaluation is not required, but may proceed on a voluntary basis if the pt chooses.) Document any interaction with the pt's commander here. |   |   |     |

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)***RECORDS  
MAINTAINED AT:** 

|   |                               |                      |
|---|-------------------------------|----------------------|
| <b>PATIENT'S NAME (Last, First, Middle Initial)</b> |                               | <b>SEX</b>           |
| <b>RELATIONSHIP TO SPONSOR</b>                      | <b>STATUS</b>                 | <b>RANK/GRADE</b>    |
| <b>SPONSOR'S NAME</b>                               |                               | <b>ORGANIZATION</b>  |
| <b>DEPART./SERVICE</b>                              | <b>SSN/IDENTIFICATION NO.</b> | <b>DATE OF BIRTH</b> |

**ATTENTION PATIENTS:**  
**COMPLETE ENTIRE**  
**"PATIENT'S IDENTIFICATION"**  
**BLOCK**

**CHRONOLOGICAL RECORD OF MEDICAL CARE**STANDARD FORM 600 (REV. 5-84)  
Prescribed by GSA and ICMR  
FIRM (41 CFR) 201-45.505

**CONTINUE HERE****II. Primary Concern**

Briefly describe the problems/concerns that brought you here.

How upsetting is the problem to you? ☐ Mild ☐ Moderate ☐ Severe

What makes the problem worse?

What makes the problem better?

What has changed in your life because of your primary concern? (for example, relationships with family and friends, your desire to have fun):

**Emotions/Behaviors**Please rate the extent to which each item below has been a problem for you over the **past month**.

|  | No<br>Problem | Mild<br>Problem | Moderate<br>Problem | Extreme<br>Problem |
|--|---------------|-----------------|---------------------|--------------------|
| <b>S:</b> Sleeping too much                          |               |                 |                     |                    |
| Difficulties falling asleep                          |               |                 |                     |                    |
| Difficulties staying asleep                          |               |                 |                     |                    |
| Waking earlier than desired                          |               |                 |                     |                    |
| <b>I:</b> Loss of interest in pleasurable activities |               |                 |                     |                    |
| <b>G:</b> Excessive guilt                            |               |                 |                     |                    |
| Feeling worthless                                    |               |                 |                     |                    |
| <b>E:</b> Decreased energy                           |               |                 |                     |                    |
| Increased energy                                     |               |                 |                     |                    |
| <b>C:</b> Difficulties with concentration/memory     |               |                 |                     |                    |
| <b>A:</b> Increased appetite                         |               |                 |                     |                    |
| Decreased appetite                                   |               |                 |                     |                    |
| <b>P:</b> Unable to sit still                        |               |                 |                     |                    |
| Moving so slowly others notice                       |               |                 |                     |                    |
| <b>S:</b> Changes in sexual interest                 |               |                 |                     |                    |
| Mood swings  |               |                 |                     |                    |
| Feeling sad or depressed                             |               |                 |                     |                    |
| Feeling nothing or feeling numb                      |               |                 |                     |                    |
| Anger  |               |                 |                     |                    |
| Temper outbursts                                     |               |                 |                     |                    |
| Regretting some behaviors (e.g., spending too much)  |               |                 |                     |                    |
| Irritability   |               |                 |                     |                    |
| Anxiety or fear                                      |               |                 |                     |                    |
| Worry about social or performance situations         |               |                 |                     |                    |
| Avoiding places, people, or situations               |               |                 |                     |                    |
| Inability to stop worrying                           |               |                 |                     |                    |
| Seeing things that others may not see                |               |                 |                     |                    |
| Hearing things that others may not hear              |               |                 |                     |                    |

**FOR STAFF USE ONLY!** (Page 2 of 10)

Primary Concern:

Emotions/Behaviors:

## HEALTH RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

**Risk Assessment**

Please check all that apply.

|  | Currently<br>(in last<br>week) | Recently<br>(in last 6<br>months) | Previously<br>(+6 months<br>ago) | Never |
|--|--------------------------------|-----------------------------------|----------------------------------|-------|
| Recurrent thoughts about death   |                                |                                   |                                  |       |
| Recurrent thoughts about killing yourself  |                                |                                   |                                  |       |
| Recurrent thoughts about killing others  |                                |                                   |                                  |       |
| Engagement in self-harming behaviors,<br>such as cutting or burning yourself,<br>without intent to die         |                                |                                   |                                  |       |
| Thinking out a plan to kill yourself   |                                |                                   |                                  |       |
| Thinking out a plan to kill others   |                                |                                   |                                  |       |
| Active preparation to kill yourself (e.g.,<br>writing goodbye letter, purchasing pills,<br>obtaining a weapon) |                                |                                   |                                  |       |
| Active preparation to kill others  |                                |                                   |                                  |       |
| Attempting to kill yourself  |                                |                                   |                                  |       |
| Attempting to kill others  |                                |                                   |                                  |       |
| Believing that others would be "better<br>off" if you die  |                                |                                   |                                  |       |
| Feeling hopeless about your life and<br>future   |                                |                                   |                                  |       |
| A family member or close friend<br>completing suicide  |                                |                                   |                                  |       |
| Voices telling you to hurt or kill yourself<br>or others   |                                |                                   |                                  |       |
| Being more physically or verbally<br>aggressive than you intended with your<br>spouse or children              |                                |                                   |                                  |       |
| A physical altercation in which you<br>caused injury   |                                |                                   |                                  |       |
| Throwing or breaking things when angry   |                                |                                   |                                  |       |
| Arrest for physical violence   |                                |                                   |                                  |       |

**III. Medical****Medication**

Please list any medications you are currently taking or have taken within the last year (include aspirin, laxatives, birth control pills, and alternative or herbal medicines)

| Medication | Dosage | For what condition? |
|------------|--------|---------------------|
|            |        |                     |
|            |        |                     |
|            |        |                     |
|            |        |                     |
|            |        |                     |
|            |        |                     |
|            |        |                     |

**FOR STAFF USE ONLY!** (Page 3 of 10)

SI:

HI:

Medications:

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS  
MAINTAINED AT: 

PATIENT'S NAME (Last, First, Middle Initial)

SEX

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**Allergies**

Are you allergic to any medications? YES NO

Are you allergic to any foods? YES NO

If YES to either of the above, please give details.

|            |           |
|------------|-----------|
| Substance: | Response: |
| Substance: | Response: |
| Substance: | Response: |
| Substance: | Response: |

Are you seeing a physician on a regular basis to deal with a medical problem?

YES NO If yes what condition?

Are you currently experiencing any pain? YES NO

If yes, what is the usual level of that pain? 0 1 2 3 4 5 6 7 8 9 10

(0 = No pain) (10 = Extreme pain)

FEMALES ONLY: Currently pregnant? YES NO

Possibly pregnant? YES NO

Last Menstrual period:

**IV. History****Mental Health History**Please check any of the following that apply to you at **any time in your life**

|   |  |
|---|--|
| Had a Commander-Directed Evaluation           | Had a substance abuse evaluation or treatment  |
| Had a Family Advocacy evaluation or treatment | Saw a chaplain for counseling  |
| Saw a school counselor for counseling         | Saw a psychiatrist, psychologist, social worker, or counselor for assessment or treatment (on or off base) |
| Saw a physician for a mental health problem   | Was given medication for a mental health problem   |

**Family Medical History**

Please check the medical conditions or treatments that apply to any members of your family. Please enter the appropriate letter(s) to indicate which family member after the condition (M=Mother, F=Father, S=Sister, B=Brother, A=Aunt, U=Uncle, GP=Grandparents).

|                            |              |                      |
|----------------------------|--------------|----------------------|
| Heart disease or condition | Anemia       | AIDS or HIV positive |
| High blood pressure        | Headaches    | Huntington's disease |
| Stroke                     | Ulcers       | Seizures             |
| Diabetes                   | Pancreatitis | Cancer               |
| Tuberculosis (TB)          | Cirrhosis    | Arthritis            |
| Thyroid Disease            | Hepatitis    | Other:               |

**Family Mental Health History**

Please check the mental health conditions or treatments that apply to any members of your family. Please enter the appropriate letter(s) to indicate which family member after the condition (M=Mother, F=Father, S=Sister, B=Brother, A=Aunt, U=Uncle, GP=Grandparents).

|                                   |  |
|-----------------------------------|--|
| Learning Disability               | Attention Deficit Hyperactivity Disorder or Attention Deficit Disorder     |
| Psychosis (such as schizophrenia) | Bipolar Disorder or Manic Depressive Illness                               |
| Alcohol or Drug Abuse             | Anxiety Disorder (such as panic disorder, phobia, or very excessive worry) |
| Mental Retardation                | Hospitalized for Mental Health Problem                                     |
| Depression                        | Other:   |

**FOR STAFF USE ONLY!** (Page 4 of 10)**Allergies:****Medical Concerns:****Current Pain:****Referral Indicated?****MH History:****If receiving off base treatment, did pt provide a release to share information with provider?****Family Medical History:****Family MH:**

## HEALTH RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*Sign each entry*)**Family Background:**

Where did you grow up? \_\_\_\_\_

Any significant past/current family problems? \_\_\_\_\_

Please check any of the following events that applied to you as a child, adolescent, or adult:

|                          |                             |                          |              |                          |                        |
|--------------------------|-----------------------------|--------------------------|--------------|--------------------------|------------------------|
| <input type="checkbox"/> | Abusive Relationship        | <input type="checkbox"/> | Rape         | <input type="checkbox"/> | Happy Childhood        |
| <input type="checkbox"/> | Experienced physical abuse  | <input type="checkbox"/> | Miscarriage  | <input type="checkbox"/> | Unhappy Childhood      |
| <input type="checkbox"/> | Experienced emotional abuse | <input type="checkbox"/> | Abortion     | <input type="checkbox"/> | Death of parent        |
| <input type="checkbox"/> | Experienced sexual abuse    | <input type="checkbox"/> | Crime victim | <input type="checkbox"/> | Death of someone close |
| <input type="checkbox"/> | Witnessed physical abuse    | <input type="checkbox"/> | War          | <input type="checkbox"/> | Filed for bankruptcy   |
| <input type="checkbox"/> | Witnessed emotional abuse   | <input type="checkbox"/> | Poverty      | <input type="checkbox"/> | Natural disaster       |
| <input type="checkbox"/> | Witnessed sexual abuse      | <input type="checkbox"/> |              | <input type="checkbox"/> |                        |

**V. Occupation**

Occupation: \_\_\_\_\_ AFSC: \_\_\_\_\_

Describe your duties at work: \_\_\_\_\_

What is your current experience with your job? (like/dislike? difficulties, trouble such as LORs, LOCs, Art 15s? trouble with coworkers? positive experiences?) \_\_\_\_\_

How has your current problem/concern affected your work? \_\_\_\_\_

When and where have you been deployed? \_\_\_\_\_

Is your current problem/concern related in any way to a deployment? Y N

If so, how? \_\_\_\_\_

Are you deploying or going TDY in the next year? Y N

If yes, where \_\_\_\_\_ when \_\_\_\_\_

What will you be doing? \_\_\_\_\_

Do you have any concerns about your deployment/TDY? Y N

Will you PCS in the next year? Y N If yes, when \_\_\_\_\_

Are you planning to separate from the service? Y N

If yes, when: \_\_\_\_\_

**FOR STAFF USE ONLY!** (Page 5 of 10)**Psychosocial History:****Occupation:****MH Concerns deployment related?****Impact on military:****Work/Military History:**PATIENT'S IDENTIFICATION (*Use this space for Mechanical Imprint*)RECORDS  
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**VI. Current Living Situation**

Briefly describe your current living situation (e.g., with whom you currently live)



Are you currently having any problems at home? (If yes, describe)

Are your relationships physically and emotionally safe?


**VII. Legal/Financial**

Are you currently experiencing any legal difficulties? Yes No

If yes, please explain: 

Is your current concern related to legal difficulties? Yes No

Are you currently experiencing any financial difficulties? Yes No

If yes, please explain: 

Is your current concern related to financial difficulties? Yes No

**VIII. Learning/Education**Is English your primary language? YES NO If no, please explain: Do you have any difficulty reading and writing? YES NO If yes, please explain: 

Check any of the following that apply to how you learn best:

|                          |                           |                          |  |
|--------------------------|---------------------------|--------------------------|--|
| <input type="checkbox"/> | Listening to others speak | <input type="checkbox"/> | Watching someone else do something         |
| <input type="checkbox"/> | Reading on my own         | <input type="checkbox"/> | Watching someone else then doing it myself |
| <input type="checkbox"/> | Talking to my peers       | <input type="checkbox"/> |  |

Please check any of the following that applied to you during your education (grade school, high school, and/or college)

|                          |             |                          |                              |                          |                 |
|--------------------------|-------------|--------------------------|------------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | Low grades  | <input type="checkbox"/> | Being involved in activities | <input type="checkbox"/> | Skiping a grade |
| <input type="checkbox"/> | High grades | <input type="checkbox"/> | Being held back a grade      | <input type="checkbox"/> | Few friends     |
| <input type="checkbox"/> | Truancy     | <input type="checkbox"/> | Being suspended or expelled  | <input type="checkbox"/> | Many friends    |

What is the highest education you have completed? GED HS diploma  
Some College Bachelor's Some Graduate Graduate Degree**IX. Coping**Who do you talk to about your problems? What do you do when you're sad? What do you do when you're angry? What do you do when you're afraid/worried? How do you spend your free time? 

What activities are fun for you? 

Are you doing them? **FOR STAFF USE ONLY!** (Page 6 of 10)**Living Situation:****Referral Indicated?****Legal/Financial:****Learning/Education:**

|                                   |        |
|-----------------------------------|--------|
| Reads/Understands English         | Yes/No |
| Understands written instructions? | Yes/No |
| Understands verbal instructions?  | Yes/No |
| Responds appropriately?           | Yes/No |
| Needs Interpreter?                | Yes/No |

**Coping/Social Support:**

## HEALTH RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*Sign each entry*)**X. Religion/Spirituality**

Do you have any concerns about your spirituality?

**XI. Substance Use****Tobacco/Caffeine:**

Do you use tobacco products? Yes No

If yes, what kind? \_\_\_\_\_

How much (e.g., packs per day)? \_\_\_\_\_

Do you use caffeinated products (e.g., coffee, tea, soda, tablets, energy drinks)? Yes No

If yes, what kind? \_\_\_\_\_

How much (e.g., servings per day)? \_\_\_\_\_

**Drugs:**

Have you overused any prescription or over-the-counter drug? YES NO

Have you used any illegal drugs now or in the past? YES NO

Have you ever been in treatment for drug use? YES NO

If yes, list year, type, frequency, and reason: \_\_\_\_\_

**Alcohol:**

Do you drink alcohol now or have you in the past (including beer and wine)? If yes, please answer the following: YES NO

How many days out of the month do you drink?

How much do you usually drink when you do drink?

Wine \_\_\_\_\_ Beer \_\_\_\_\_ Hard alcohol \_\_\_\_\_

How often do you drink to get drunk or to get away from stressors per month? \_\_\_\_\_

Has your alcohol use increased in the past month? YES NO

Have you had problems in your relationships with friends or family due to alcohol use? YES NO

Have you had problems at work or at home due to alcohol use? YES NO

Have you blacked out in the past from drinking alcohol? YES NO

Have you ever been in treatment for use of alcohol (including ADAPT, AA, Rational Recovery, etc.)? YES NO

Have you had trouble with the law due to alcohol use (e.g., DUI, drinking underage, public intoxication, alcohol-related violence)? YES NO

Do you drive after drinking alcohol? YES NO

**FOR STAFF USE ONLY!** (Page 7 of 10)**Religion/Spirituality:****Substance Use:**

Nicotine:

Caffeine:

Illegal drugs:

Alcohol:

ADAPT referral indicated? \_\_\_\_\_

PATIENT'S IDENTIFICATION (*Use this space for Mechanical Imprint*)**RECORDS****MAINTAINED AT:** ►PATIENT'S NAME (*Last, First, Middle Initial*)

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**XII. Nutrition**

Do you have any nutritional concerns? \_\_\_\_\_

**XIII. GOALS FOR TREATMENT**

What do you want to change about yourself?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Specific Goals**In coming to this center, I would like to concentrate on..... (Check any that apply). Note the 3 most important goals with **1, 2, & 3.**

|   |   |
|---|---|
| <input type="checkbox"/> Feeling less depressed                       | <input type="checkbox"/> Improving family relationship                      |
| <input type="checkbox"/> Feeling less anxious/fearful                 | <input type="checkbox"/> Improving marital relationship                     |
| <input type="checkbox"/> Feeling less angry                           | <input type="checkbox"/> Improving work relationship                        |
| <input type="checkbox"/> Better managing my temper                    | <input type="checkbox"/> Improving communication skills                     |
| <input type="checkbox"/> Feeling more self-confident                  | <input type="checkbox"/> Improving relationship with....(complete the goal) |
| <input type="checkbox"/> Feeling less guilt                           | <input type="checkbox"/> Improving my sexual relationship                   |
| <input type="checkbox"/> Better managing my health or pain            | <input type="checkbox"/> Reducing my sensitivity to criticism               |
| <input type="checkbox"/> Doubting myself less                         | <input type="checkbox"/> Controlling my eating or weight                    |
| <input type="checkbox"/> Better tolerating my mistakes                | <input type="checkbox"/> Learning how I come across to others               |
| <input type="checkbox"/> Having more fun                              | <input type="checkbox"/> Receiving medication help                          |
| <input type="checkbox"/> Better accepting a loss/death                | <input type="checkbox"/> Adjusting better to a recent change                |
| <input type="checkbox"/> Talking out a pending decision               | <input type="checkbox"/> Discussing thoughts of harming self                |
| <input type="checkbox"/> Discussing desire for separation/discharge   | <input type="checkbox"/> Allowing myself to express feelings more           |
| <input type="checkbox"/> Learning how to relax                        | <input type="checkbox"/> Not taking disappointments so hard                 |
| <input type="checkbox"/> Thinking more positively                     | <input type="checkbox"/> Learning problem-solving techniques                |
| <input type="checkbox"/> Not reacting so emotionally                  | <input type="checkbox"/> Learning how to improve friendships                |
| <input type="checkbox"/> Improving my sleep                           | <input type="checkbox"/> Adjusting better to a past incident                |
| <input type="checkbox"/> Worrying less about..... (complete the goal) | <input type="checkbox"/> Discussing thoughts of harming others              |
| <input type="checkbox"/> Better tolerating my mistakes                | <input type="checkbox"/> Controlling my use of alcohol or drugs             |
| <input type="checkbox"/> Expressing myself more assertively           |   |

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ SSN \_\_\_\_\_

*Thank you for completing this portion of the assessment.*  
**STOP: PLEASE TURN IN YOUR QUESTIONNAIRE**

Technician Stamp/ Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider Stamp/Signature \_\_\_\_\_ Date \_\_\_\_\_

**FOR STAFF USE ONLY!** (Page 8 of 10)**Nutrition:****Referral indicated?****Goals:**Goals:

1.

2.

3.

Plan:

1.

2.

3.

**Mental Health Provider Additional Comments:**



| HEALTH RECORD   | CHRONOLOGICAL RECORD OF MEDICAL CARE  |                  |                 |                                   |                  |                        |                  |        |                |       |       |         |        |          |               |                    |        |          |         |      |         |        |                          |        |            |     |         |       |                |                 |             |         |           |         |           |                        |  |              |         |               |            |               |        |                  |        |         |             |              |          |          |        |                      |        |          |             |                          |  |  |        |                    |    |        |  |      |  |       |           |                      |        |               |  |                      |  |        |        |                               |  |         |               |                                   |  |  |        |                    |        |          |          |                 |  |        |  |                 |        |                 |      |      |           |           |        |                |      |                  |      |         |      |        |        |
|---|---|------------------|-----------------|-----------------------------------|------------------|------------------------|------------------|--------|----------------|-------|-------|---------|--------|----------|---------------|--------------------|--------|----------|---------|------|---------|--------|--------------------------|--------|------------|-----|---------|-------|----------------|-----------------|-------------|---------|-----------|---------|-----------|------------------------|--|--------------|---------|---------------|------------|---------------|--------|------------------|--------|---------|-------------|--------------|----------|----------|--------|----------------------|--------|----------|-------------|--------------------------|--|--|--------|--------------------|----|--------|--|------|--|-------|-----------|----------------------|--------|---------------|--|----------------------|--|--------|--------|-------------------------------|--|---------|---------------|-----------------------------------|--|--|--------|--------------------|--------|----------|----------|-----------------|--|--------|--|-----------------|--------|-----------------|------|------|-----------|-----------|--------|----------------|------|------------------|------|---------|------|--------|--------|
| <b>Mental Health Clinic</b><br><b>99MDOS/SGOWH</b><br><b>Nellis AFB, NV 89191</b>   | <p style="text-align: center;">SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (<i>Sign each entry</i>)</p> <p style="text-align: center;"><b>MHC Record</b> <span style="float: right;"><b>Page 9 of 10</b></span></p> |                  |                 |                                   |                  |                        |                  |        |                |       |       |         |        |          |               |                    |        |          |         |      |         |        |                          |        |            |     |         |       |                |                 |             |         |           |         |           |                        |  |              |         |               |            |               |        |                  |        |         |             |              |          |          |        |                      |        |          |             |                          |  |  |        |                    |    |        |  |      |  |       |           |                      |        |               |  |                      |  |        |        |                               |  |         |               |                                   |  |  |        |                    |        |          |          |                 |  |        |  |                 |        |                 |      |      |           |           |        |                |      |                  |      |         |      |        |        |
| <p><b>Date/Time:</b></p> <p><b>Duration:</b></p> <p>Type Visit: New Patient Intake</p> <p><b>S:</b></p> <p><b>O: MSE (circle all that apply):</b></p> <p><b>1. General Appearance and Behavior</b></p> <table style="width: 100%;"> <tr> <td><i>Dress</i></td> <td>BDUs</td> <td>Blues</td> <td>civilian attire</td> <td>well groomed</td> <td>sloppily dressed</td> <td>other:</td> </tr> <tr> <td><i>Bearing</i></td> <td>rigid</td> <td>tense</td> <td>slumped</td> <td>slowed</td> <td>restless</td> <td>tremor other:</td> </tr> <tr> <td><i>Eye contact</i></td> <td>normal</td> <td>fleeting</td> <td>avoided</td> <td>none</td> <td>staring</td> <td>other:</td> </tr> <tr> <td><i>Facial expression</i></td> <td>normal</td> <td>responsive</td> <td>sad</td> <td>neutral</td> <td>angry</td> <td>worried other:</td> </tr> <tr> <td><i>Attitude</i></td> <td>cooperative</td> <td>passive</td> <td>resistant</td> <td>hostile</td> <td>sarcastic</td> <td>threatening suspicious</td> </tr> <tr> <td></td> <td>manipulative</td> <td>guarded</td> <td>argumentative</td> <td>respectful</td> <td>disrespectful</td> <td>other:</td> </tr> </table> <p><b>2. Cognition</b></p> <table style="width: 100%;"> <tr> <td><i>Attention</i></td> <td>normal</td> <td>unaware</td> <td>inattentive</td> <td>distractible</td> <td>confused</td> <td>vigilant</td> <td>other:</td> </tr> <tr> <td><i>Concentration</i></td> <td>normal</td> <td>variable</td> <td>preoccupied</td> <td colspan="3">focuses on irrelevancies</td> <td>other:</td> </tr> <tr> <td><i>Orientation</i></td> <td>X4</td> <td>person</td> <td></td> <td>time</td> <td></td> <td>place</td> <td>situation</td> </tr> <tr> <td><i>Recall/memory</i></td> <td>normal</td> <td colspan="2">defective in:</td> <td colspan="2">immediate/short-term</td> <td>recent</td> <td>remote</td> </tr> <tr> <td><i>Estimated Intelligence</i></td> <td></td> <td>average</td> <td>below average</td> <td colspan="3">above average needs investigation</td> <td>other:</td> </tr> <tr> <td><i>Abstraction</i></td> <td>normal</td> <td>concrete</td> <td>abstract</td> <td colspan="2">overly abstract</td> <td colspan="2">other:</td> </tr> <tr> <td><i>Judgment</i></td> <td>normal</td> <td>common-sensical</td> <td>fair</td> <td>poor</td> <td>impulsive</td> <td>dangerous</td> <td>other:</td> </tr> <tr> <td><i>Insight</i></td> <td>good</td> <td>uses connections</td> <td>gaps</td> <td>unaware</td> <td>poor</td> <td>denial</td> <td>other:</td> </tr> </table> <p><b>3. Thought and language</b></p> <p><i>Speech</i> amount _____ rate _____ volume _____ emotional tone/inflection _____<br/> <small>(minimally responsive? verbose?) (slow? pressured?) (soft, loud) (gestures? spirited?)</small></p> <p><i>Thought content</i> appropriate delusions paranoia personalizations other: _____</p> <p><i>Preoccupations</i> none phobias somatic suicide homicide guilt religion other: _____</p> <p><i>Thought process</i> logical goal-directed circumstantial loose perseverations other: _____</p> <p><b>4. Affect &amp; Mood</b></p> <p>Current Mood _____ "Typical" mood _____</p> <p><i>Affect</i> restricted appropriate wide flat detached responsive dramatic labile congruent w/stated mood</p> <p><i>Observed Mood</i> Calm Cheerful Anxious Depressed Tearful Pessimistic Optimistic Euphoric Irritable Angry</p> <p><i>Additions</i> Mood _____ Affect _____</p> <p><b>5. Suicidality/Homicidality</b></p> <p><b>Risk Factors:</b></p> <p><b>Protective Factors:</b></p> <p><b>Patient's Risk Level:</b> not elevated / mild / moderate / severe /extreme</p> <p><b>Patient's risk category is:</b></p> <p><b>Baseline:</b> no history of suicide attempts;</p> <p><b>Acute:</b> Presence of acute crisis, significant stressors or suicidal symptomatology</p> <p><b>Chronic High Risk:</b> Baseline for multiple attempters; no acute stressors or symptomatology</p> <p><b>Chronic High Risk w/ Acute Exacerbation:</b> Acute risk category for multiple attempters</p> |   | <i>Dress</i>     | BDUs            | Blues                             | civilian attire  | well groomed           | sloppily dressed | other: | <i>Bearing</i> | rigid | tense | slumped | slowed | restless | tremor other: | <i>Eye contact</i> | normal | fleeting | avoided | none | staring | other: | <i>Facial expression</i> | normal | responsive | sad | neutral | angry | worried other: | <i>Attitude</i> | cooperative | passive | resistant | hostile | sarcastic | threatening suspicious |  | manipulative | guarded | argumentative | respectful | disrespectful | other: | <i>Attention</i> | normal | unaware | inattentive | distractible | confused | vigilant | other: | <i>Concentration</i> | normal | variable | preoccupied | focuses on irrelevancies |  |  | other: | <i>Orientation</i> | X4 | person |  | time |  | place | situation | <i>Recall/memory</i> | normal | defective in: |  | immediate/short-term |  | recent | remote | <i>Estimated Intelligence</i> |  | average | below average | above average needs investigation |  |  | other: | <i>Abstraction</i> | normal | concrete | abstract | overly abstract |  | other: |  | <i>Judgment</i> | normal | common-sensical | fair | poor | impulsive | dangerous | other: | <i>Insight</i> | good | uses connections | gaps | unaware | poor | denial | other: |
| <i>Dress</i>  | BDUs  | Blues            | civilian attire | well groomed                      | sloppily dressed | other:                 |                  |        |                |       |       |         |        |          |               |                    |        |          |         |      |         |        |                          |        |            |     |         |       |                |                 |             |         |           |         |           |                        |  |              |         |               |            |               |        |                  |        |         |             |              |          |          |        |                      |        |          |             |                          |  |  |        |                    |    |        |  |      |  |       |           |                      |        |               |  |                      |  |        |        |                               |  |         |               |                                   |  |  |        |                    |        |          |          |                 |  |        |  |                 |        |                 |      |      |           |           |        |                |      |                  |      |         |      |        |        |
| <i>Bearing</i>  | rigid   | tense            | slumped         | slowed                            | restless         | tremor other:          |                  |        |                |       |       |         |        |          |               |                    |        |          |         |      |         |        |                          |        |            |     |         |       |                |                 |             |         |           |         |           |                        |  |              |         |               |            |               |        |                  |        |         |             |              |          |          |        |                      |        |          |             |                          |  |  |        |                    |    |        |  |      |  |       |           |                      |        |               |  |                      |  |        |        |                               |  |         |               |                                   |  |  |        |                    |        |          |          |                 |  |        |  |                 |        |                 |      |      |           |           |        |                |      |                  |      |         |      |        |        |
| <i>Eye contact</i>  | normal  | fleeting         | avoided         | none                              | staring          | other:                 |                  |        |                |       |       |         |        |          |               |                    |        |          |         |      |         |        |                          |        |            |     |         |       |                |                 |             |         |           |         |           |                        |  |              |         |               |            |               |        |                  |        |         |             |              |          |          |        |                      |        |          |             |                          |  |  |        |                    |    |        |  |      |  |       |           |                      |        |               |  |                      |  |        |        |                               |  |         |               |                                   |  |  |        |                    |        |          |          |                 |  |        |  |                 |        |                 |      |      |           |           |        |                |      |                  |      |         |      |        |        |
| <i>Facial expression</i>  | normal  | responsive       | sad             | neutral                           | angry            | worried other:         |                  |        |                |       |       |         |        |          |               |                    |        |          |         |      |         |        |                          |        |            |     |         |       |                |                 |             |         |           |         |           |                        |  |              |         |               |            |               |        |                  |        |         |             |              |          |          |        |                      |        |          |             |                          |  |  |        |                    |    |        |  |      |  |       |           |                      |        |               |  |                      |  |        |        |                               |  |         |               |                                   |  |  |        |                    |        |          |          |                 |  |        |  |                 |        |                 |      |      |           |           |        |                |      |                  |      |         |      |        |        |
| <i>Attitude</i>   | cooperative   | passive          | resistant       | hostile                           | sarcastic        | threatening suspicious |                  |        |                |       |       |         |        |          |               |                    |        |          |         |      |         |        |                          |        |            |     |         |       |                |                 |             |         |           |         |           |                        |  |              |         |               |            |               |        |                  |        |         |             |              |          |          |        |                      |        |          |             |                          |  |  |        |                    |    |        |  |      |  |       |           |                      |        |               |  |                      |  |        |        |                               |  |         |               |                                   |  |  |        |                    |        |          |          |                 |  |        |  |                 |        |                 |      |      |           |           |        |                |      |                  |      |         |      |        |        |
|   | manipulative  | guarded          | argumentative   | respectful                        | disrespectful    | other:                 |                  |        |                |       |       |         |        |          |               |                    |        |          |         |      |         |        |                          |        |            |     |         |       |                |                 |             |         |           |         |           |                        |  |              |         |               |            |               |        |                  |        |         |             |              |          |          |        |                      |        |          |             |                          |  |  |        |                    |    |        |  |      |  |       |           |                      |        |               |  |                      |  |        |        |                               |  |         |               |                                   |  |  |        |                    |        |          |          |                 |  |        |  |                 |        |                 |      |      |           |           |        |                |      |                  |      |         |      |        |        |
| <i>Attention</i>  | normal  | unaware          | inattentive     | distractible                      | confused         | vigilant               | other:           |        |                |       |       |         |        |          |               |                    |        |          |         |      |         |        |                          |        |            |     |         |       |                |                 |             |         |           |         |           |                        |  |              |         |               |            |               |        |                  |        |         |             |              |          |          |        |                      |        |          |             |                          |  |  |        |                    |    |        |  |      |  |       |           |                      |        |               |  |                      |  |        |        |                               |  |         |               |                                   |  |  |        |                    |        |          |          |                 |  |        |  |                 |        |                 |      |      |           |           |        |                |      |                  |      |         |      |        |        |
| <i>Concentration</i>  | normal  | variable         | preoccupied     | focuses on irrelevancies          |                  |                        | other:           |        |                |       |       |         |        |          |               |                    |        |          |         |      |         |        |                          |        |            |     |         |       |                |                 |             |         |           |         |           |                        |  |              |         |               |            |               |        |                  |        |         |             |              |          |          |        |                      |        |          |             |                          |  |  |        |                    |    |        |  |      |  |       |           |                      |        |               |  |                      |  |        |        |                               |  |         |               |                                   |  |  |        |                    |        |          |          |                 |  |        |  |                 |        |                 |      |      |           |           |        |                |      |                  |      |         |      |        |        |
| <i>Orientation</i>  | X4  | person           |                 | time                              |                  | place                  | situation        |        |                |       |       |         |        |          |               |                    |        |          |         |      |         |        |                          |        |            |     |         |       |                |                 |             |         |           |         |           |                        |  |              |         |               |            |               |        |                  |        |         |             |              |          |          |        |                      |        |          |             |                          |  |  |        |                    |    |        |  |      |  |       |           |                      |        |               |  |                      |  |        |        |                               |  |         |               |                                   |  |  |        |                    |        |          |          |                 |  |        |  |                 |        |                 |      |      |           |           |        |                |      |                  |      |         |      |        |        |
| <i>Recall/memory</i>  | normal  | defective in:    |                 | immediate/short-term              |                  | recent                 | remote           |        |                |       |       |         |        |          |               |                    |        |          |         |      |         |        |                          |        |            |     |         |       |                |                 |             |         |           |         |           |                        |  |              |         |               |            |               |        |                  |        |         |             |              |          |          |        |                      |        |          |             |                          |  |  |        |                    |    |        |  |      |  |       |           |                      |        |               |  |                      |  |        |        |                               |  |         |               |                                   |  |  |        |                    |        |          |          |                 |  |        |  |                 |        |                 |      |      |           |           |        |                |      |                  |      |         |      |        |        |
| <i>Estimated Intelligence</i>   |   | average          | below average   | above average needs investigation |                  |                        | other:           |        |                |       |       |         |        |          |               |                    |        |          |         |      |         |        |                          |        |            |     |         |       |                |                 |             |         |           |         |           |                        |  |              |         |               |            |               |        |                  |        |         |             |              |          |          |        |                      |        |          |             |                          |  |  |        |                    |    |        |  |      |  |       |           |                      |        |               |  |                      |  |        |        |                               |  |         |               |                                   |  |  |        |                    |        |          |          |                 |  |        |  |                 |        |                 |      |      |           |           |        |                |      |                  |      |         |      |        |        |
| <i>Abstraction</i>  | normal  | concrete         | abstract        | overly abstract                   |                  | other:                 |                  |        |                |       |       |         |        |          |               |                    |        |          |         |      |         |        |                          |        |            |     |         |       |                |                 |             |         |           |         |           |                        |  |              |         |               |            |               |        |                  |        |         |             |              |          |          |        |                      |        |          |             |                          |  |  |        |                    |    |        |  |      |  |       |           |                      |        |               |  |                      |  |        |        |                               |  |         |               |                                   |  |  |        |                    |        |          |          |                 |  |        |  |                 |        |                 |      |      |           |           |        |                |      |                  |      |         |      |        |        |
| <i>Judgment</i>   | normal  | common-sensical  | fair            | poor                              | impulsive        | dangerous              | other:           |        |                |       |       |         |        |          |               |                    |        |          |         |      |         |        |                          |        |            |     |         |       |                |                 |             |         |           |         |           |                        |  |              |         |               |            |               |        |                  |        |         |             |              |          |          |        |                      |        |          |             |                          |  |  |        |                    |    |        |  |      |  |       |           |                      |        |               |  |                      |  |        |        |                               |  |         |               |                                   |  |  |        |                    |        |          |          |                 |  |        |  |                 |        |                 |      |      |           |           |        |                |      |                  |      |         |      |        |        |
| <i>Insight</i>  | good  | uses connections | gaps            | unaware                           | poor             | denial                 | other:           |        |                |       |       |         |        |          |               |                    |        |          |         |      |         |        |                          |        |            |     |         |       |                |                 |             |         |           |         |           |                        |  |              |         |               |            |               |        |                  |        |         |             |              |          |          |        |                      |        |          |             |                          |  |  |        |                    |    |        |  |      |  |       |           |                      |        |               |  |                      |  |        |        |                               |  |         |               |                                   |  |  |        |                    |        |          |          |                 |  |        |  |                 |        |                 |      |      |           |           |        |                |      |                  |      |         |      |        |        |

PATIENT'S IDENTIFICATION (*Use this space for Mechanical Imprint*)

|   |                        |
|---|------------------------|
| <b>RECORDS MAINTAINED AT:</b>                         |                        |
| PATIENT'S NAME ( <i>Last, First, Middle Initial</i> ) | SEX                    |
| RELATIONSHIP TO SPONSOR                               | STATUS                 |
| SPONSOR'S NAME  | ORGANIZATION           |
| DEPART./SERVICE                                       | SSN/IDENTIFICATION NO. |
| DATE OF BIRTH   |                        |

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)  
 Prescribed by GSA and ICMR  
 FIRM (41 CFR) 201-45.505

Mental Health Clinic  
99MDOS/SGOWH  
Nellis AFB, NV 89191

## Vital Signs:

|    |    |   |    |        |        |
|----|----|---|----|--------|--------|
| BP | HR | T | RR | Height | Weight |
|----|----|---|----|--------|--------|

**A: Diagnoses**

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V: GAF present: \_\_\_\_\_ GAF estimated highest: \_\_\_\_\_

Profile (circle one): Profile Initiated: Y/N

If placing on profile at this time, length of profile/ date of release:

Duty limitations:

Mobility limitations:

**P: PLAN**

1. Patient's plan currently includes:

☐ Individual therapy: with (provider) \_\_\_\_\_ on (date/time) \_\_\_\_\_☐ Medication(s): \_\_\_\_\_☐ Group therapy (specify): \_\_\_\_\_☐ Referral(s) to: \_\_\_\_\_☐ Placement on the High Risk List☐ Following person was contacted to notify of increased risk or impairment: *spouse CC 1<sup>st</sup> Sgt PCM friend other:*☐ Patient briefed on emergency procedures

1. 0730-1630 M-F, call (653-3880) or walk-in to MHC.

2. After hours and on weekends, call 9-1-1 and/or walk-in to the MOFH emergency dept.

3. Call 911 for life-threatening situation or injury.

☐ Hospitalization **is / is not** necessary. Rationale:☐ At current time, outpatient care **can / cannot** provide sufficient safety and stability. Intervention plan for safety is:

(consider removal of guns or other means of self-harm; consider crisis response plan)

1.

2.

3.

**Treatment Plan:** (See p. 8 of MHC Record Intake Evaluation Report for details)**Risks, Benefits, Side Effects & Alternatives Discussed: Yes/No****PREVENTION:** Identified and discussed importance of prevention in following areas:☐ Tobacco Use ☐ Alcohol Use ☐ Caffeine Use ☐ Inactivity ☐ Exercise ☐ Social Support☐ Sleep ☐ Sexual Behavior ☐ Safety ☐ Domestic Violence ☐ Nutrition☐ Other \_\_\_\_\_ ☐ Comments \_\_\_\_\_

Provider Signature Block \_\_\_\_\_

Provider Signature \_\_\_\_\_